California Health Policy and Data Advisory Commission
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Minutes
California Health Policy and Data Advisory Commission
December 8, 2006

The meeting was called to order by Vito Genna, Chair, at approximately 9:00 a.m., at the Sir Francis Drake Hotel in San Francisco, California.

Present:

Vito J. Genna, Chairperson
William Brien, MD
Marjorie Fine, MD
Janet Greenfield, RN
Howard L. Harris, PhD
Jerry Royer, MD, MBA
Corinne Sanchez, Esq.
Josh Valdez, DBA
William Weil, MD

Absent:

Sol Lizerbram
Kenneth M. Tiratira, MPA

CHPDAC Staff: Kathleen Maestas, Acting Executive Director; Terrence Nolan, Office Manager

OSHPD Staff: David M. Carlisle, MD, PhD, Director; Elizabeth Wied, Chief Counsel; Michael Rodrian, Deputy Director, Healthcare Information Division; Joseph Parker, PhD, Manager, Health Quality and Analysis Division; Jonathan Teague, Manager, Healthcare Information Resources Center; Kenny Kwong, Manager, Accounting and Reporting Systems; Candace Diamond, Manager, Patient Data Section; Starla Ledbetter, Research Program Specialist II, Patient Data Section; and Debra Holstien, Healthcare Information Division

Others Present: Jacquelyn Paige, Consultant; Stephen C. Clark and George L. Koortbojian, Health Care Consultants; Kathy McCaffrey, California Health Information Association; and Socorro Sosa, University of California

Approval of Minutes: The minutes from the October 16, 2006 meeting were approved as mailed.

Calendar Set for 2007: The California Health Policy and Data Advisory Commission will meet in Southern California on the following dates: February 23, 2007; June 22,

2007; and October 19, 2007. The Commission will meet in Northern California on April 20, 2007; August 24, 2007 and December 7, 2007.

Chairman's Report**:** A motion was made at the last meeting to release the Community-Acquired Pneumonia study, and only include the letter from Kaiser in the Summary. Kaiser indicated that it ended up as an outlier because of medical records coding, and that patients might have come from board and care facilities. There was extensive discussion at the meeting with regard to the statistic that patients from nursing homes are sicker when they enter the hospital and more prone to bad outcomes. Commissioner Fine stated that the institutional setting tends to have more use of antibiotics, more tube feedings and other types of interventions that could predispose patients to a different type of pneumonia. These factors come into play in defining patients initially as to whether they are community-acquired or institutional.

Chairperson Genna indicated that there is a report related to this in the American Journal of Medical Quality. The article stated that hospital-acquired infections and other poor outcomes result mostly from poor hygiene within the facilities and are not predicated on how sick the patients were at the time of admission. In addition with surgeries, the number of persons coming through the operating room had more bearing than how debilitated the person was.

OSHPD staff has met with the California Nurse Outcomes Coalition (CalNOC), which was interested in exploring the relationship between nursing care and outcomes for community-acquired pneumonia. OSHPD will work with that organization to validate the role of nursing and validate the quality assessments that are made of hospitals. Additionally, it is felt that nursing data will help clarify other factors about the processes of care.

The distribution of the publication, Perspectives in Healthcare, to legislators is timely, since the Governor is forming a team to look at the uninsured issue and other healthcare issues. Perspectives in Healthcare will be a valuable resource in dealing with decisions relating to healthcare. Many states are looking at ways to deal with runaway healthcare cost under Medicare and the uninsured issue. The New York Commission Study calling for a revamping of healthcare, including the closure of hospitals and nursing homes was discussed.

The Chairman asked former Commission Executive Director, and HDPIC member, Jacquelyn Paige to give some history of the Commission.

Recognizing that the California Health Facilities Commission (CHFC) was scheduled to sunset on January 1, 1986, the 1983-84 Legislature created the Health Data and Advisory Council Consolidation Act which transferred the Commission's duties to the Office of Statewide Health Planning and Development upon the sunset. The legislation also eliminated the State Advisory Health Council and the Certificate of Need program. The Data Act created the California Health Policy and Data Advisory Commission.

The first Director of CHPDAC, Dale Houghland, was appointed by the Commission, with approval from the former Health and Welfare Agency Secretary, and held the position until

he passed away in March 1990. At the end of 1990, the Administration decided that the Director should be appointed at the pleasure of the Administration to lead this statutorily mandated, bipartisan Commission. Jacquelyn Paige was appointed Director at the end of 1990, and continued to serve until her retirement in May 2005.

When Ms. Paige was appointed, the Commission had the following committees: Hospital Data Committee, Long-Term Care Data Committee, Cost Containment Committee, Appeals Committee, and Public Liaison Committee.

The Hospital and Long-Term Care Committees often were presented with the same material, and were later combined to create the Hospital and Long-Term Care Committee. The Public Liaison Committee was responsible for a mandatory report on activities to promote health information collected by OSHPD and disseminated to major stakeholders in healthcare delivery. This report was later eliminated by legislation which reduced the number of mandatory reports produced by various departments under the Health and Human Services.

The Cost Containment Committee produced a bi-annual cost containment report and published a report, Variations in Cesarean Section Rates in California, June 1991. A Cesarean Section Work Group was created to follow practice patterns, cesarean section rates, VBACS (Vaginal Birth after Cesarean Section), etc.

The Appeals Committee handled appeals from facilities which were late in filing their annual disclosure reports. Facilities were fined $100 per day for late submission and could appeal the fines to a three-member Appeals Committee.

In 1992, the AB 524 Technical Advisory Committee was appointed to work on risk-adjusted outcome studies. Over the next few years, OSHPD produced reports on acute myocardial infarction, maternal outcomes, community-acquired pneumonia and Coronary Artery Bypass Grafts studies.

In the early 1990s, there was an effort to identify data sources and data needs for various groups, including departments, legislators, legislative committees, schools, providers, purchasers, etc., to determine their value and share important data among the various stakeholders. This led to two bills which were instrumental in medical reporting for California.

SB 1109 required CHPDAC to assess the value and usefulness of reports prepared pursuant to three specified provisions and to make specific recommendations to OSHPD. It also required the establishment of a committee (called the California Health Information Committee) with specified membership to implement the evaluation process. Two subcommittees were formed, hearings were held, and 40 individuals and organizations testified. Recommendations were then developed, focusing on the State's future health information needs.

A report was released in December 1996, which recommended the improvement of timeliness of patient discharge data, followed by a review of existing financial and

utilization databases to evaluate the potential for combining, streamlining or eliminating reporting requirements.

In 1998, legislation required OSHPD to develop a new online reporting system, which became operational for data submission in March of 2002. This system was called MIRCal. Phase one required hospitals to report inpatient discharge data online. The second phase required hospital emergency and ambulatory surgery departments and free-standing ambulatory surgery clinics to begin reporting patient discharge data to OSHPD.

In the late 1990's, a report by the Institute of Medicine, To Err is Human, was released. The Commission created a Committee to Advance Patient Safety, Privacy and Care. The Committee worked to promote electronic medical records to reduce errors, improve patient safety, support providers, and support a continuum of care.

The Health Economics Committee was formed at the urging of Commissioner Hugo. In order to graduate from public high school in California, students were mandated to take one semester of economics. Prior to this mandate, students were graduating with no understanding that the decisions they were making would follow them for the rest of their lives, particularly in the area of healthcare, such as smoking, car accidents, teen-age pregnancies, etc. The Commission published a report called, Speaking about the Economics of Health and a Resource Guide, which were sent to all 1,200 school districts in the State of California. The economics professors participating in this effort used the material in their classes, but there was not much interest by others to include health-related kinds of economics into the curriculum at that time.

Ms. Paige represented the Commission on OSHPD's Executive Council, and worked on charity care, health data, quality, nursing and workforce issues, and participated in many advisory groups for other state and national organizations and stakeholders. The Committee for the Protection of Human Subjects was placed under Ms. Paige's supervision for a few years before her retirement which coincided with a significant increase in the workload of CPHS.

Ms. Paige urged Commissioners to remember their appointing authority and share with them activities done by the Commission, OSHPD, and Health and Human Services Agency. She also urged the Commission to continue to invite outside persons to make presentations about what is happening in healthcare delivery.

Ms. Paige especially lauded Perspectives in Healthcare, stating that it is a brilliant publication, containing a wealth of healthcare information, divided into county specific perspectives. She stated that this document, published under the directorship of Dr. Carlisle, by Jonathan Teague and his staff, should be widely distributed and recognized for its usefulness. And with the collection of emergency room and ambulatory surgery data, OSHPD will be able to add to this valuable document.

Ms. Paige encouraged undertaking special projects, as time and staff permits, and specifically cited the continuing use of interns as very beneficial to the department.

Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

This is the beginning of a new legislative session, with about a 30 percent turnover of legislators. The chair of the Assembly Health Committee is Mervin Dymally and the chair of the Senate Health Committee is Sheila Kuhl. OSHPD will be working very closely with them.

Cliff Allenby, Director of the Department of Social Services, and Kathryn Campisi, Director of the Department of Rehabilitation, have announced their retirement at the end of the year.

Teresa Smanio, OSHPD Assistant Director for Legislative and Public Affairs, will be retiring at the end of the year. Angela Smith Minniefield, Deputy Director of the Health Professions Education Foundation, has agreed to return to the Health Professions Foundation until a new permanent Executive Director is appointed. Stephanie Clendenen, Accounting Officer, is also managing the Foundation with Ms. Minniefield.

Effective July 2007, the Department of Health Services will be split into two separate departments. A new Department of Public Health will be responsible for all public health activities in the State of California. A Department of Medi-Cal Services will administer the State's Medi-Cal program.

Healthcare reform will be high priority for the Governor. As mentioned before, there is a working group on healthcare reform which includes: John Ramey, former Director of the MRMIB program, Herb Schultz, a leader of the Department of National Healthcare under the Davis Administration, Richard Figueroa, an expert on health policy in Sacramento, Ruth Lui, healthcare actuarial from Kaiser Permanente, and Kimberly Belshé, Secretary of the Health and Human Resources Agency.

Health Data and Public Information Committee Report: Howard L, Harris, PhD, Chair

The HDPIC met on November 14, and discussed the community-acquired pneumonia report, Health Perspectives publication, and AB 774 charity care proposed regulations.
The Committee explored the development of the administrative regulations and how compliance with the regulations will be achieved, and gave input. Implementation may prove to be more challenging. An issue raised was the definition of family versus household and that there may be different definitions of "family." The attorney pointed out that the legislation includes a definition of "patient family" for the program.

Presentation/Discussion on Chapter 755, Statutes 2006 (AB 774, Chan) – "Hospitals: Fair Pricing Policies": Kenny Kwong, Manager, Accounting and Reporting Systems Section

Over the past four years, several similar charity bills have been proposed, predicated on a similar concept where a patient would be eligible for partial charity care and not expected to pay any more than what Medicare, Medi-Cal, Worker's Compensation, Healthy Families pays.

Some of the stumbling blocks in the early version were that rural hospitals were being held to the same FPL income levels as the urban hospitals. Earlier versions of the bill also had hefty penalties for noncompliance and were vague.

The intent of the statute is to regulate hospital charges and the collection procedures for the uninsured and the under-insured by increased public awareness of the availability of charity care and awareness of government-sponsored health programs such as Medi-Cal, Healthy Families, and other Department of Health Services' programs. The intent is to have hospitals clarify and inform the consumer on its billing and collection practices.

The law applies to all hospitals licensed under Health and Safety Code Section 1250, which are general acute care hospitals, acute psychiatric hospitals, and special hospitals, and becomes effective January 1, 2007. Compliance with the bill is a condition of licensure and will be enforced by Department of Health Services. In discussions with DHS, it was learned that the Audits and Investigations Branch will do more of the detail compliance audit.

Hospitals must maintain understandable written policies for charity care and discount payments and must state the process used by the hospital to determine eligibility. The discount payment policy must provide an extended payment plan to be negotiated between the patient and the hospital. All patients must have a family income level at or below 350 percent of the federal poverty level (FPL) and be uninsured. The insured must be below 350 percent of FPL, aren't offered a third-party discount, and have high medical costs. Rural hospitals can establish an FPL lower than 350.

The patient's out-of-pocket hospital costs must be greater than ten percent of their annual income over the last 12 months or their documented out-of-pocket medical costs are greater than ten percent. The bill limits the amount a patient is expected to pay to the higher of what Medicare pays, or Medi-Cal, Healthy Families, and other government-sponsored medical plans.

Commissioner Fine suggested that the middle income group might be motivated to opt out of health insurance because they would have the opportunity to get the discounted rate.

The bill places restrictions on how monetary assets could be used in making the determination for eligibility. Hospitals are not allowed to use retirement or deferred compensation plans with respect to eligibility. The first $10,000 of a patient's monetary assets cannot be used.

Inpatients would have to be notified of availability of charity care and discount payments at the time of pre-admission. For outpatients, it would probably be when registering in the ER. Hospitals are required to post notices of availability of charity care and discount payments in their ER, admitting office, billing office, and other outpatient locations. Notices must be language appropriate if more than five percent of the people served do not speak or understand English.

The bill requires a statement of specific charges when a patient is initially billed. The hospital must provide information on the government-sponsored health programs and

instructions on how to obtain applications for Medi-Cal and Healthy Families. Hospitals have a waiting period of 150 days after billing before they can take adverse action for nonpayment. The extended payment plan negotiated between the hospital and the patient is interest free. Hospitals must establish policies on their debt collection processes.

The bill does not specify a minimum amount of charity care, a floor for the FPL in order to obtain free charity care, the scope of services covered, or types of income that can be used. There has been some discussion between the author and California Hospital Association on clean-up legislation to address these issues.

Each hospital must report five separate items to OSHPD: charity care policy, discount payment policy which is partial charity care, eligibility procedures, review process and application form. During the implementation phase, OSHPD must develop and adopt regulations, and develop an on-line collection plan. Submission to OSHPD would not occur until 2008. Hospitals must submit information to OSHPD every two years. If significant changes are made, revised documents must be submitted. If no significant changes are made, OSHPD can simply be notified that the previously submitted policy is still in effect.

OSHPD is required to make the information available to the public and it needs to be patient and consumer friendly, and available on the internet. OSHPD will meet with industry representatives in the development of the online reporting system.

Hospital Fair Pricing Policies: Steve Clark & George Koortbojian of Clark, Koortbojian & Associates

Steve Clark, a member of the Health Information and Public Information Committee, and his business partner, George Koortbojian, have been working in the charity care arena for some time as consultants to public hospitals, not-for-profit hospitals and investor-owned hospitals to build effective programs. All the hospitals are experiencing similar problems. It is their impression that the charity care legislation is too loosely worded and confusing. OSHPD's Hospital and Accounting Reporting Manual contains definitions for discounts and charity care. In the context of AB 774, use of the word "discounts" is what is traditionally known as partial charity care, involving an evaluation of an individual's ability to pay. Definitions and terminology need to be consistent.

It is their feeling that hospitals need to make changes in practice and operations, printing and programming changes and implement a system to document that a patient has been provided information on discounts and charity care. Medically necessary services needs to be defined. Mr. Koortbijian stated that it is his impression that foreign nationals will have a significant impact on border hospitals. In addition, there could be a further shift of employers purchasing high deductible plans in order to save operating costs for premiums which could lead to free care for the truly disadvantaged and low income people being eliminated.

There are problems around what is considered monetary assets using income tax or pay stubs. Hospitals can specify in its eligibility requirements if income tax or pay stubs are used. Mr. Koortbijian asked, "What constitutes income?" The law does not say if

attestation can be used of where income is derived. The law limits the ability to evaluate a patient's monetary assets and the ability to evaluate other assets such as real and tangible property are lost.

The law does not say that the hospital must agree to a payment plan, but only says it must negotiate a plan with the patient.

Mr. Koortbojian stated that there is a potential conflict with Medicare rules with regard to assets. Medi-Cal has a prohibition for writing off share of cost. What happens to the patient who qualifies because of their income for a hospital program, but is denied because of share of cost rules in the Medi-Cal program?

The law says that charity care information cannot be shared for collection purposes, so firewalls will need to be built.

Mr. Koortbojian stated that there will be a problem in implementing a program for providing the consumer fair debt collection notices because of costly billing and programming changes. The cost to the hospitals will greatly exceed the cost to OSHPD to implement the program.

There needs to be clarity in the AB 774 law and a reasonable timeframe for implementation. Coordinated regulations for enforcement of the law need to be done by DHS and OSHPD, and DHS and OSHPD need to use the same definitions and be consistent. There needs to be practical phased enforcement, and recognition of good faith efforts by the hospitals.

Suggestion was made to have a representative from DHS attend the next Health Data and Public Information Committee meeting.

Healthcare Information Division Report: Joe Parker, PhD, Candace Diamond and Starla Ledbetter from Healthcare Information Division

Expanding Patient Data Section– Joe Parker

There has been some movement in the area of expanding the patient discharge data to include additional information, including clinical data. Distribution of the report by Dr. Andrew Bindman to committees and interested stakeholders revealed that OSHPD needs to make a good business argument for collection of additional data elements. There needs to be a follow-up plan for data verification and validation after the data are collected. Some data elements such as lab values are readily available and do not require chart abstraction. There has been some prioritization of the data elements which OSHPD is interested in capturing.

The electronic medical record is on the horizon and the State may have a role in helping hospitals understand what data elements need to be collected. About 90 percent of laboratory values are already automated at California hospitals. The voluntary California Hospital Assessment & Reporting Taskforce (CHART) is collecting clinical data from hospitals for some measures. Nationally, hospitals are reporting that they need better risk

adjustment factors, many of which are clinical elements. Lab values and pharmacology are pretty well automated.

Lab values, patient identifying information, and vital signs have been identified as high priority items for OSHPD to collect. OSHPD is interested in assessing patient risk at admission to a hospital. OSHPD has a "condition present at admission code" and by adding clinical laboratory values, true hospital performance can be better identified. There needs to be a discussion on how valuable collection of vital signs would be, in relation to the lab values.

Patient address information is valuable for both health policy research and for providers, since it enables geographical-based analyses as to access to care, ambulance diversion, and local services utilization and availability. SB 680 mandates OSHPD to identify and report patient primary language, and there are more than one hundred. There will be more discussion on the collection of new data elements at the Technical Advisory Committee and HDPIC meetings.

National Standards: Starla Ledbetter

OSHPD staff has been very involved with national organizations in development of national standards, and have worked on "condition present at admission" and "do-not-resuscitate" in the past and currently working on principal language spoken.

A national provider identifier will be effective in May 2007, which will require regulations. This national ID would not replace the OSHPD ID used

Condition present on admission indicator has been captured by OSHPD for many years. The national standard is slightly different, using four categories instead of California's three.

There currently exists a list of ICD9-CM codes, which are status codes that would be exempt from reporting. In addition to reporting this on principal and secondary diagnoses, it would be required on external cause of injury code reporting, effective March 1, 2007 for hospitals using paper bills. An implementation date has not been adopted for hospitals using electronic transactions.

Effective October 1, 2007, two conditions will be chosen which will report condition present on admission. These will be high cost or high volume conditions, resulting in a higher paying DRG if it was a secondary diagnosis and could have been prevented through application of evidence-based guidelines. In October 2008, if the condition occurred after admission, the hospital will not receive additional payment.

The organizations are working on a consolidated severity grouper, which will be a better severity of illness system to classify all the diagnoses. Adoption of ICD-10 and claims attachments showing the lab values are imminent.

Enhancements to MIRCal: Changes to the MIRCal system infrastructure will bring the system up to date with both hardware and software. OSHPD is working to have principal

language identified as a national standard. Some preliminary work with census information and other California programs has been done. The inpatient data elements need to be moved to the national standards, to be consistent with emergency departments and ambulatory surgery data. This would require changes to almost all the data elements. A project is underway to facilitate the submission of CABG data to the MIRCal system.

Outreach: Candace Diamond

The stakeholders have been very willing to work with OSHPD staff on focus groups to add clinical data elements. All of the inpatient data elements will adhere to national standards. Business cases need to be built to justify collection of the additional data elements. Information technology and budgetary approvals need to be obtained and there will be incremental changes. Regulation changes will probably take one year to accomplish, which includes discussions with stakeholders and public hearings.

Healthcare Information Resource Center: Jonathan Teague, Manager

Copies of the Perspectives in Healthcare Report are available on CD-ROM, which is a primary mode of distribution. A teaser brochure will be distributed.

Adjournment: The meeting adjourned at 1:05 p.m.